OUTPATIENT THERAPY SERVICES PAYMENT SYSTEM

*payment***basics**

Revised: October 2019

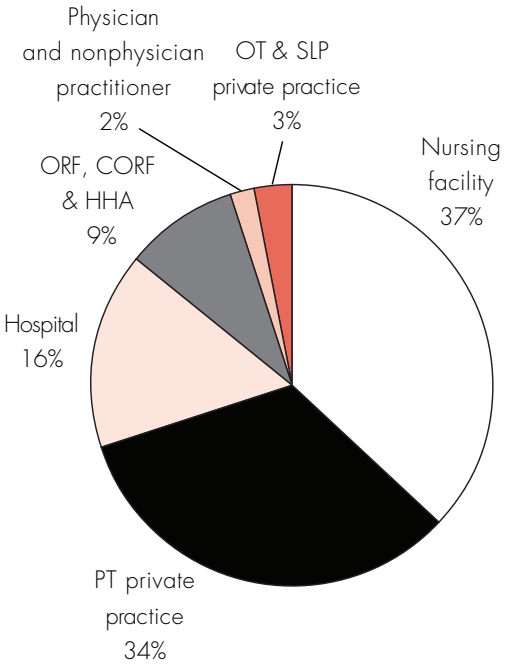
Outpatient therapy services include three separate categories of services that aim to improve and restore function that patients have lost after an illness or injury, help patients maintain their current condition, and prevent or slow further deterioration of a patient's condition: physical therapy (PT), occupational therapy (OT), and speech–language pathology (SLP) services. PT services include therapeutic exercise; manual therapy; patient education; and other interventions to improve strength and mobility, restore and maintain function, and increase independence. Examples of outcomes include improved ability to stand, lift, carry, and walk independently. OT services are aimed at improving or maintaining a patient's ability to perform activities of daily living, such as bathing, dressing, and managing medications. Therapies may focus on motor skills, lifting, bending, feeding, and time management. SLP services help patients restore and maintain the ability to communicate, swallow, and speak. For example, a patient who has had a stroke may receive SLP services to recover the ability to speak. SLP services include guided drills and training to improve speech and swallowing functions.

Medicare covers outpatient therapy services if the beneficiary's need for therapy is documented in a written treatment plan developed by the therapist, a physician, or a nonphysician practitioner (NPP) after consultation with a qualified therapist. A physician or NPP must certify the plan of care every 90 days. The prescribed course of therapy must be reasonable and necessary to treat the individual's illness or injury. Among other requirements, covered therapy services must qualify as skilled therapy services that are appropriate for treatment of the patient's condition.

Medicare spending on outpatient therapy services was $8.0 billion in 2017, an increase of 6 percent from 2016. PT services accounted for 72 percent of all spending on therapy services, while OT and SLP services accounted for 20 percent and 8 percent, respectively.

Outpatient therapy is furnished in nursing homes, hospital outpatient departments, physicians' offices, outpatient rehabilitation facilities, and comprehensive outpatient rehabilitation facilities, as well as by therapists in private practice and home health agencies. Outpatient therapy services provided in nursing homes and by physical therapists in private practice account for 71 percent of Medicare therapy spending, with hospital outpatient departments accounting for 16 percent in 2017 (Figure 1).

Figure 1 Distribution of outpatient therapy spending by setting, 2017



Note: PT (physical therapist), ORF (outpatient rehabilitation facility), CORF (comprehensive outpatient rehabilitation facility), HHA (home health agency), OT (occupational therapy), SLP (speech–language pathology). Numbers may not sum to 100 percent due to rounding.

Source: MedPAC analysis of 100 percent Medicare Part B outpatient therapy claims, 2017.

This document does not reflect proposed legislation or regulatory actions.

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Medicare covers therapy services furnished by physicians or by physical therapists, occupational therapists, and speech–language pathologists in their respective disciplines. Medicare also covers therapy services furnished by physician assistants, nurse practitioners, and clinical nurse specialists if permitted by the state in which the provider practices. Qualified physical and occupational therapy assistants may also provide therapy services when supervised by a physical or occupational therapist. Athletic trainers, chiropractors, nurses, and nurse aides do not meet the qualification and training requirements for therapists and therefore can not bill Medicare for therapy services.

Defining the services Medicare pays for

The unit of payment is each individual outpatient therapy service. All services are classified according to the Healthcare Common Procedure Coding System (HCPCS). Most physical therapy and occupational therapy HCPCS codes are defined in 15-minute increments, but most SLP services are not.

Setting the payment rates

Medicare pays for outpatient therapy under Medicare's fee schedule for physicians and other health professionals in all settings except for critical access hospitals.

Under the fee schedule, each HCPCS code has a separate payment rate that is based on a relative weight, expressed as relative value units (RVUs), which account for the relative costliness of the inputs used to provide the service: the clinician's work, practice expenses, and professional liability insurance (PLI). The RVUs for the clinician's work reflect the relative levels of time, effort, skill, and stress associated with providing each service. The RVUs for practice expenses are based on the cost of renting office space, buying supplies and equipment, and hiring nonphysician clinical and administrative staff. The PLI RVUs are based on the premiums clinicians pay for professional liability insurance.

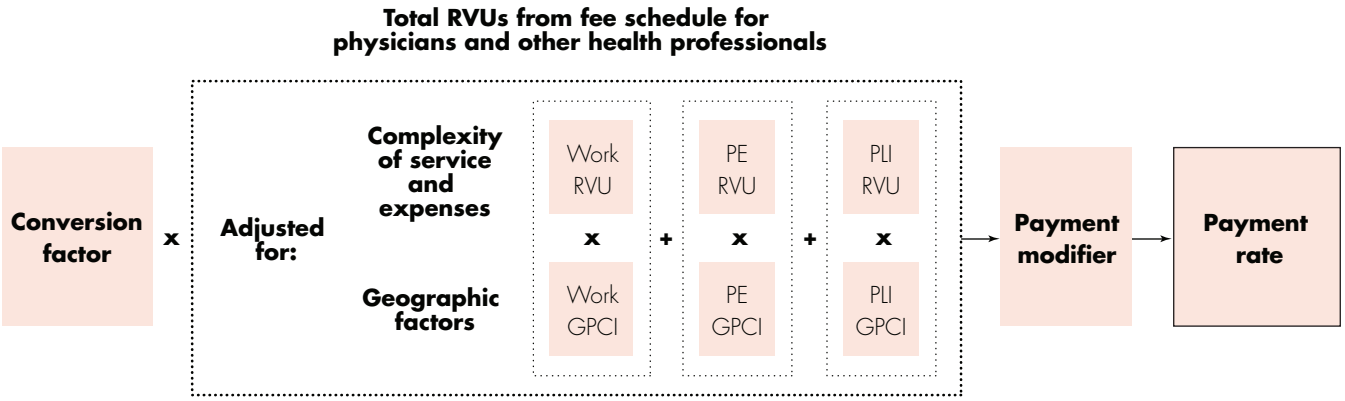
In calculating a payment rate for each service, each of the three RVUs is adjusted to reflect the prices of inputs in the local market where the service is furnished. Separate geographic practice cost indexes are used for this purpose. The fee schedule payment amount is then determined by summing the adjusted RVUs and multiplying the total by a standard dollar amount (the conversion factor, which was $36.04 in 2019) (Figure 2). Medicare pays the provider 80 percent of the fee schedule amount, and the beneficiary is liable for the remaining 20 percent. Through payment modifiers, Medicare may adjust its payments upward or downward to reflect various factors. For example, Medicare applies a multiple procedure payment reduction to the practice expense component of therapy services when multiple services are furnished by the same provider to the same patient on the same day. When this occurs, CMS reduces the practice expense payment for the second and subsequent therapy services by 50 percent. The rationale for this policy is that efficiencies occur when multiple therapy services are furnished in a single session because certain clinical staff activities are only performed once per session.

Updating payments

CMS reviews the RVUs of new, revised, and some potentially misvalued services annually. HCPCS codes and the conversion factor are also updated annually. The update of RVUs includes a review of changes in medical practice, coding changes, new data, and the addition of new services. In updating the RVUs, CMS receives advice from a group of physicians and other professionals sponsored by the American Medical Association and specialty societies.

The annual updates to the conversion factor are set in statute by the Medicare Access and CHIP Reauthorization Act of 2015 and the Bipartisan Budget Act of

Figure 2 Payment rates for outpatient therapy services



Note: RVU (relative value unit), GPCI (geographic practice cost index), PE (practice expense), PLI (professional liability insurance). This figure depicts Medicare program payments only.

2018 (BBA). The update in 2019 was 0.25 percent.

Outpatient therapy caps

To constrain excessive spending and use, the Congress enacted two caps on annual per beneficiary spending for outpatient therapy services: one for physical therapy and SLP services combined and another for occupational therapy services. The annual cap amount was unrelated to each patient's condition. Consequently, the cap policy raised concerns that it could restrict access to medically necessary services. These concerns led the Congress to create an exceptions process to the caps, which allowed beneficiaries to exceed the annual spending cap if the therapy provider certified that continued therapy services were medically necessary.

The BBA permanently repealed the caps effective January 1, 2018. However, therapy providers must still certify that therapy services are medically necessary when annual per beneficiary spending for physical therapy and SLP services combined or for occupational therapy reaches a certain threshold (in 2019, the threshold is $2,040).

Targeted medical review process

CMS is required by statute to conduct targeted medical reviews of therapy services for the highest spending beneficiaries—those whose annual spending exceeds $3,000 for physical therapy and SLP services combined or for occupational therapy. In deciding which services to target for review, CMS may consider services furnished by providers with high claims denial rates, patterns of billing that are unusual compared with their peers, or other factors. ■